

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/26/2014
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NAME OF PROVIDER OR SUPPLIER  NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 107 A VILLA CT BRAZIL, IN 47834
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W000000	<p>This visit was for a post certification revisit (PCR) to the investigation of complaint #IN00147727 investigated on 5/12/14.</p> <p>Complaint #IN00147727 - Not corrected.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: June 24, 25 and 26, 2014</p> <p>Provider Number: 15G592 Aims Number: 100240070 Facility Number: 001106</p> <p>Surveyor: Mark Ficklin, QIDP.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed July 2, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview,</p>	W000154	The facility will have evidence	07/25/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>the facility failed to thoroughly investigate 2 of 2 incidents reviewed for allegations of (physical aggression) client to client abuse (clients A, F, H).</p> <p>Findings include:</p> <p>Record review of the facility incident reports was done on 6/24/14 at 2:50p.m. Client F had the following incident reports of physical aggression to peers: On 5/25/14, while on the van, client F grabbed client H's left arm. The report indicated client H had 5 dime sized bruises and a superficial scratch to his left arm/elbow area.; On 6/6/14, client F bit clients A on the right shoulder and client G on the left ear. The bites left teeth marks on the clients. The report indicated no known cause for the 6/6/14 incident. There was no documented investigation completed for the 5/25/14 incident. The facility's "Client to Client Aggression Investigation Statement" completed for the 6/6/14 incident did not have interviews of all staff and clients involved and did not identify where all staff were at the time of the incident.</p> <p>Professional staff #1 was interviewed on 6/24/14 at 4:02p.m. Staff #1 indicated there was no documented investigation for client to client aggression which occurred on 5/25/14. Staff #1 indicated</p>		<p>that all incidents/ injuries of unknown origin are thoroughly investigated and documented.</p> <p>This incident has been thoroughly investigated at this time to include statements from all staff members and clients as possible and including information as to the location of staff at the time of the incident. The QIDP is responsible for insuring that any follow-up identified is initiated and completed in order to ensure the safety of the individuals.</p> <p>The agency has current policies and procedures that prohibit the mistreatment, neglect and abuse of the individuals served as well as policies that specifically address the reporting of and completion of investigations of unknown injuries or incidents.</p> <p>The Home Manager, Program Coordinator/QMRP have completed re-training on the</p>				

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	<p>the facility should have completed a "Client to Client Aggression Investigation Statement" form, that was to be used for client to client aggression. Staff #1 indicated the investigation for the 6/6/14 incident did not have documented interviews of all staff involved.</p> <p>This deficiency was cited on 5/12/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00147727.</p> <p>9-3-2(a)</p>		<p>facility policies and procedures regarding their responsibilities to insure that all incidents as defined by the policy are reported immediately and investigated thoroughly. The Program Coordinator/ QMRP is responsible for initiating and completing initial investigation of injuries of unknown origin. The Program Director is responsible for insuring that these incidents of unknown origin are thoroughly investigated and follow-up is completed within the established timelines. The Executive Director will complete this re-training with these staff members at this time and the Program Manager will be responsible to see that training is completed on at least an annual basis.</p> <p>The Program Director is responsible for insuring that all incidents of unknown origin are thoroughly investigated, follow-up is</p>		

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			<p>completed within the established timelines, and that all identified service needs are addressed and presented to the IDT as necessary. The QIDP, Nurse, Program Director and Executive Director will complete a review all incident reports (internal and external) to determine that all injuries of unknown origin are investigated thoroughly and documented. The facility has a specific written format in which injuries of unknown origin are to be investigated and documented. The completed investigation will now be attached to the original Incident Report for review. If there are additional questions or concerns that result from these reviews, they will be addressed immediately.</p> <p>The Safety Committee will review the Investigations of Unknown Origin on at least a quarterly basis to complete an analysis of trends and noted issues. Any issues noted will</p>		

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W000214	<p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. Based on record review and interview, the facility failed for 1 non-sampled client (F) to assess/identify client F's behavioral needs.</p> <p>Findings include:</p> <p>Record review of the facility incident reports was done on 6/24/14 at 2:50p.m. Client F had the following incident reports: On 5/25/14, while on the van, client F grabbed client H's left arm. The report indicated client H had 5 dime sized bruises and a superficial scratch to his left arm/elbow area.; On 6/6/14, client F bit clients A on the right shoulder and client G on the left ear. The bites left teeth marks on the clients. The report indicated no known cause for the 6/6/14 incident. Client F had no documented incidents of physical aggression from 1/1/14 through 5/25/14.</p> <p>Record review of client F was done on 6/24/14 at 3:30p.m. Client F's 12/13 Behavior Support Plan had behavior tracking for "Stereotypical Behaviors"</p>			W000214	<p>be followed up immediately.</p> <p>The Behavior Management Program regarding Client F has been revised and implemented according to the needs identified by the comprehensive functional assessment. The QIDP has received training on expectations to assure all identified needs from an individual's ISP are addressed. The QIDP will review all client ISP's for the home to assure all identified needs are being addressed. The Program Manager will be responsible for this training and assuring ISP audit is thoroughly completed and followed up. The QIDP is responsible to insure that each individual's needs identified are addressed in their Individual Program Plan and addressed formally as recommended by the IDT. The QIDP is responsible to provide information to the Home Manager and staff as to the protocols and formal objectives that they must initiate to meet each individuals needs and assist them toward independence. The QIDP will provide training to all staff in the home on the specific implementation of the revised plan. Data will be collected by staff in order to track progress of</p>		07/25/2014

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	<p>which were identified as: rocking back and forth, drooling, grinding teeth, and biting himself when he does not get his own way. The BSP did not identify client physical aggression to others. Client F's record did not have any documentation of the facility's programming teams' assessment of client F's 2 recent incidents of physical aggression to peers. There was no documentation client F had physical aggression to peers from 1/1/14 through 5/25/14.</p> <p>Staff #1 was interviewed on 6/24/14 at 4:02p.m. Staff #1 indicated client F had been assessed for medical issues and had visited the psychiatrist after the 6/6/14 incident. Staff #1 indicated client F had no medical issues identified and had received a behavior medication increase. Staff #1 indicated the facility did not have a documented interdisciplinary team meeting to address any new programming needs for client F after client F's 2 recent displays of physical aggression to peers. Staff #1 indicated client F's current assessments and programs in place did not address causes and any interventions and training needs in regards to the recent display of physical aggression. Staff #1 indicated client F was in need of a functional assessment of identified behaviors.</p>		<p>the plan. The QIDP will monitor data collected on at least a monthly basis to determine any issues or progress made and will revise as needed. The QIDP is responsible for reviewing the individual program plans with the IDT on at least a quarterly basis to review progress made or needed revisions. The QIDP is responsible for providing staff with on-going training concerning individual program plans and objectives that are in place to address the specific needs of each client. The Clinical Supervisor and/or the Program Manager is responsible for reviewing each client's individual program plan on at least a quarterly basis to ensure that objectives are being initiated as written and that needs are being addressed and monitored for progress.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

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	9-3-4(a)				